Form - 301

Metro Employee Benefit Board
IOD Benefits

IOD OUT-OF-POCKET EXPENSE REIMBURSEMENT FORM

Employee Name: _____

Address: _____

Phone: _____

Department: _____

Date of Injury: _____

Body Part Injured: _____

Total amount requested for reimbursement: $_____

Please complete the top portion, read and sign the certification and attach any receipt(s) that you have for reimbursement. You must attach the receipt along with proof of purchase or co-payment or this will be returned for completion.

I hereby certify that I have paid in full the charges for which I am requesting reimbursement and that I have not submitted these expenses to any other insurance, flexible spending account or other source for reimbursement.

_____ _____

Signature Date

Submit receipts/proof of payment to:

ASC
Metro IOD Program
P.O. Box 291587
Nashville, TN 37229-1587
Fax: 615-360-5692